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Mental Health Legal Advisors Committee (MHLAC)

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Providing Free Legal Assistance for DYS involved Youth in Massachusetts

The Mental Health Legal Advisors (MHLAC), an independent state agency of the Supreme Judicial Court, assists children and adults with mental health disabilities. We provide advice and legal representation on a wide range of issues. Our intake line is open Mon., Wed., & Fri. from 8:30 a.m. to 1 p.m., (617) 338-2345, x. 20.

MHLAC's DYS Project

MHLAC advises and represent DYS-involved youth on civil legal matters. We are available to assist youth and their families on a range of legal issues, and are particularly interested in access to mental health care and education. We also offer trainings to advocates, parents and youth on legal rights within the DYS system. For information, please contact:

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New Massachusetts law expands children's mental health system

In 2000, researchers estimated that between 50 to 75 percent of incarcerated youth across the nation had a diagnosable mental health disorder.[1] In 2004, researchers concluded that 60 to 70 percent of youth involved in the Massachusetts Department of Youth Services (DYS) facilities were clinically in need of mental health care.[2] In Massachusetts, youth with unmet mental health needs often become involved in the juvenile justice system and sometimes involved with DYS. As parents, advocates and youth can attest to, accessing appropriate and comprehensive mental health services within the juvenile justice system can be challenging. A new state law provides important remedies to some of the barriers that youth face in accessing these services.

On August 21, 2008, Governor Deval Patrick signed Chapter 231, An Act Relative to Children's Mental Health (Chapter 231). The law strengthens the children's mental health system in Massachusetts by improving the early identification of children with mental health needs, ensuring the appropriate delivery of mental health services in the least restrictive setting, expanding insurance coverage, and restructuring the provision and coordination of state mental health services.

Early identification The first of these goals, early identification, could help keep youth out of the juvenile justice system. This preventative approach to health care is accomplished by reaching out to children in comfortable settings such as pediatricians' offices, early education programs, and schools. Specifically, Chapter 231 orders the Office of Medicaid to convene a working group on the identification of children's behavioral health problems in pediatric primary care setting and to establish reimbursement rates for pediatricians for behavioral health screenings.[3] Parents should request screenings and take advantage of reimbursements by the state.

The law also supports early identification in early education programs, the state Department of Early Education and Care (DEEC) will spearhead, with an explicit goal of reducing suspension and expulsion rates. A 2005 study revealed that Massachusetts has the 9th highest rate of expulsion of pre-kindergarten children in the country.[4] Chapter 231 charges DEEC with several responsibilities designed to keep young children in school and identify youth who need behavioral health interventions. Specifically, DEEC will provide consultations and trainings to meet the behavioral health needs of children in the programs it licenses,[5] report on its own capacity to provide mental

State and federal mental health parity laws improve mental health insurance coverage

For many years, children and adults with mental illness have been routinely subject to discriminatory treatment from health insurers. Historically, most employers and group health plans have not provided the same level of coverage for mental health treatment as the plans have provided for physical illness. These differences were visible with respect to deductibles, copayments, frequency of treatment, and number of visits.

Despite this history, legislators at the federal and state level have both passed laws in the past year to end this discriminatory treatment by health insurers. These laws will require plans to provide equal coverage of mental and physical illness.

Massachusetts parity law Under the new Massachusetts mental health parity law,[1] Chapter 256 of the Acts of 2008, which was enacted August 5, 2008, health plans may not have annual or lifetime limits, in dollars or number of visits, for the diagnosis and treatment of certain mental disorders, which are lower than the limits on coverage for diagnosis and treatment of physical conditions. In other words, financial requirements and treatment limitations of mental health coverage will be no more restrictive than those for physical conditions.

Additionally, the state parity law requires insurers who offer mental health benefits to cover the diagnosis and treatment of certain mental illnesses to the same extent that they cover the diagnosis and treatment of physical disorders. Insurers subject to the Massachusetts mental health parity law must provide full parity in coverage for mental

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health services and the most effective intervention and prevention strategies,[6] and develop a plan to provide training to identify and address early childhood behavior health needs.[7]

Further, the law establishes a task force on behavioral health and public schools to assess the capacity of Massachusetts schools to address children's behavioral health needs and offer recommendations for statewide policies that promote effective delivery of mental health services in schools.[8] Additionally, MassHealth, the state's Medicaid program, will work in collaboration with the Department of Mental Health (DMH) and the Department of Elementary and Secondary Education, to develop a proposal for the provision of mental consultative services to school.[9]

Appropriate delivery of mental health services in the least restrictive setting The law requires the Executive Office of Health and Human Service (EOHHS) to implement new policies and procedures to guarantee that children do not become "stuck" in hospitals and are treated in the least restrictive, most appropriate setting. Towards this goal, the Secretary of EOHHS will publish a monthly report of children awaiting clinically appropriate behavioral health services.[10] The Department of Child and Families (DCF) and the DMH also will file monthly reports on their efforts to move "stuck kids" to appropriate settings.[11] When a child is in the care and custody of DCF and/or is eligible for DMH services, Chapter 231 outlines the requirements of these departments in moving children to appropriate settings. When a child's discharge plan includes alternative residential placement, DCF or DMH will immediately begin discharge planning including coordination of post-hospital care. Five days after being notified that continued hospitalization is no longer clinically appropriate, DMH or DCF will determine the appropriate type of placement for the child and shall immediately initiate the placement referrals. If a child is still "stuck" after 30 days, DMH or DCF will refer the child to the interagency review teams established by the law.[12]

Improved insurance coverage for children with mental health needs Chapter 231 improves insurance coverage for children with mental health needs. Under the law, behavioral health manager companies are obligated to notify their consumer as to their rights and the obligations of the company.[13] The parent HMO is held accountable for any behavioral health manger company that does not comply with the law.[14] Also, the law requires HMOs to provide written notice to their members if the HMO cannot provide a service within its network; then the HMO shall obtain and cover such out-of-network service.[15]

Greater interagency communication and coordination of care The law ensures greater interagency communication and the coordination of care related to mental health needs to ensure effective delivery of services and to prevent kids from falling through the cracks. The law bolsters the link between DMH and DYS, as it requires state agencies, including DYS, to consult with the Commissioner of DMH regarding the design and implementation of behavioral health services in DYS.[16]

Early identification, treatment in the most appropriate setting, expansion of insurance coverage, and the restructuring of state mental health services will allow parents and professionals to have improved access to information, support and resources, recognize mental health problems and provide appropriate services to prevent and treat problem behavior which can ultimately result in involvement in the juvenile justice system.

Implementation of the law is in its beginning stages. For more information regarding the law and its implementation, see http://www.childrensmentalhealthcampaign.org. ♦

[1] Handle With Care: Serving the Mental Health Needs of Young Offenders. CJJ 2000 Annual Report. Washington, D.C.: Coalition for Juvenile Justice, 2000.
[2] Grisso, T., et al., Mental Health and Juvenile Justice Systems: Responding to the Needs of Youth with Mental Health Conditions and Delinquency, Center for Mental Health Services Research, University of Massachusetts Medical School, Vol. 1 Issue 3, March 2004, p.1.http://www.umassmed.edu/cmhsr/uploads/Brief3JJsystem.pdf.
[3] St. 2008, c. 321, § 18.
[4] Gilliam, W.S. Prekindergarteners Left Behind: Expulsion Rates in State Prekindergarten Systems. New Haven, CT: Yale University Child Study Center, 2005.
[5] St. 2008, c. 321, § 2
[6] St. 2008, c. 321, § 3.
[7] St. 2008, c. 321, § 5
[8] St. 2008, c. 321, § 19.
[9] St. 2008, c. 321, § 20
[10] St. 2008, c. 321, § 1.
[11] St. 2008, c. 321, § 8; St. 2008, c. 321, § 9.
[12] Ibid.
[13] St. 2008, c. 321, § 13.
[14] St. 2008, c. 321, § 15.
[15] St. 2008, c. 321, § 14.

State and federal parity laws *Continued from page 1*

disorders that are "biologically-based," specifically: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; and affective disorders. Starting July 1, 2009, eating disorders, post traumatic stress disorders, substance abuse disorders, and autism will be included in the diagnoses given parity. In addition to full parity coverage of designated biologically-based disorders, insurers must cover medically necessary treatment of other mental disorders for a minimum of 60 days inpatient care and 24 outpatient visits per year.

Under parity, children under age 19 receive even broader coverage. The plan must provide parity coverage for the diagnosis and treatment of non-biologically based mental, behavioral or emotional disorder which "substantially interfere with or substantially limit the functioning and social interactions of such a child."

With respect to the Department of Youth Services (DYS), the state mental health parity law does not require those private insurers to pay for mental health services for youth in DYS custodial facilities when those services are covered by other health insurance plans (i.e. MassHealth). However, when youth are released from DYS facilities, their families should be sure to check with MassHealth or their previous provider about mental health coverage.

Federal Parity law The federal parity law, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, H.R. 6983, covers self-insured employer group health plans, which are not covered by the Massachusetts law. The law amends the federal Mental Health Parity Act of 2006 to require that coverage of treatment for mental illness and substance use under "self-funded" plans or group health plans of 50 or more employees is no more restrictive than coverage of treatment for physical ailments. The new federal law becomes effective for most plans in January 2010.

The passage of the state and federal parity laws provide an opportunity for a multitude of individuals to receive adequate mental health care. In addition, together, they will play a significant role in ending the stigma and discrimination related to mental illness. ♦

[1] Not all health plans are subject to the Massachusetts law. Medicaid and most out-of-state plans contracting with out-of-state employers are not considered to fall under the state law on parity. M.G.L.A. c. 175, § 110 (A). Self-funded plans, usually offered by big employers, are only subject to the federal law. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, H.R. 6983, 110th Cong. § 2(c)(2).